Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

AMENDED MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
CENTER FOR PAIN RELIEF

Respondent Name
HARTFORD ACCIDENT & INDEMNITY COMPANY

MFDR Tracking Number
M4-13-2497-02

Carrier's Austin Representative
Box Number 47

MFDR Date Received
May 29, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The carrier is denying payment of Code 64510 in error."

Amount in Dispute: $294.56

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Hartford's investigation has found the following: . . . Original billing processed in accordance with Medical Fee Guidelines, Rule 134.202 & 134.203."

Response Submitted by: The Hartford

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 3, 2013 to January 17, 2013	Procedure Code 64510	$294.56	$0.00

AMENDED FINDINGS AND DECISION

This amended findings and decision supersedes all previous decisions rendered in this medical fee dispute between the above requestor and respondent.

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the fee guidelines for professional medical services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - B13 – PREVIOUSLY PAID. PAYMENT FOR THIS CLAIM/SERVICE MAY HAVE BEEN PROVIDED IN A PREVIOUS PAYMENT.
   - 536 – THE CHARGES HAVE ALREADY BEEN BILLED AND PAID FOR ACCORDING TO FEE SCHEDULE AND/OR REASONABLE GUIDELINES. NO FURTHER PAYMENT IS DUE
   - 4063 – REIMBURSEMENT IS BASED ON THE PHYSICIAN FEE SCHEDULE WHEN A PROFESSIONAL SERVICE WAS PERFORMED IN THE FACILITY SETTING.

Issues

1. What is the recommended payment amount for the services in dispute?
2. Is the requestor entitled to reimbursement?

Findings

1. This dispute relates to professional medical services with reimbursement subject to the provisions of 28 Texas Administrative Code §134.203(c), which requires that "To determine the MAR [Maximum Allowable Reimbursement]for professional services, system participants shall apply the Medicare payment policies with minimal modifications. (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is $52.83 . . . (2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year." Review of box 24 B on the medical bill finds the Place of Service code listed as 22, which indicates that the services were performed in an outpatient hospital facility setting. The applicable Division conversion factor for surgery performed in a facility setting for calendar year 2013 is $69.43. Reimbursement is calculated as follows:
   - Procedure code 64510, service date January 3, 2013, represents a professional service with reimbursement determined per §134.203(c). The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 1.22 multiplied by the geographic practice cost index (GPCI) for work of 1.009 is 1.23098. The practice expense (PE) RVU of 0.89 multiplied by the PE GPCI of 1.017 is 0.90513. The malpractice RVU of 0.1 multiplied by the malpractice GPCI of 0.834 is 0.0834. The sum of 2.21951 is multiplied by the Division conversion factor of $69.43 for a MAR of $154.10.
   - Procedure code 64510, service date January 17, 2013, represents a professional service with reimbursement determined per §134.203(c). The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 1.22 multiplied by the geographic practice cost index (GPCI) for work of 1.009 is 1.23098. The practice expense (PE) RVU of 0.89 multiplied by the PE GPCI of 1.017 is 0.90513. The malpractice RVU of 0.1 multiplied by the malpractice GPCI of 0.834 is 0.0834. The sum of 2.21951 is multiplied by the Division conversion factor of $69.43 for a MAR of $154.10.
2. The total allowable reimbursement for the services in dispute is $308.20. Review of the submitted documentation finds that the insurance carrier has previously paid $308.18. No additional reimbursement is recommended.

Conclusion

For the reasons stated above, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the services in dispute.

Authorized Signature

	Grayson Richardson	September 2, 2014
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.